



General Assembly

January Session, 2013

Raised Bill No. 6612

LCO No. 4244



Referred to Committee on INSURANCE AND REAL ESTATE

Introduced by:
(INS)

***AN ACT CONCERNING THE HEALTH INSURANCE GRIEVANCE
PROCESS FOR ADVERSE DETERMINATIONS, THE OFFICE OF THE
HEALTHCARE ADVOCATE AND MENTAL HEALTH PARITY
COMPLIANCE CHECKS.***

Be it enacted by the Senate and House of Representatives in General
Assembly convened:

1 Section 1. Subdivision (38) of section 38a-591a of the general statutes
2 is repealed and the following is substituted in lieu thereof (*Effective*
3 *October 1, 2013*):

4 (38) "Urgent care request" means a request for a health care service
5 or course of treatment (A) for which the time period for making a non-
6 urgent care request determination [(A)] (i) could seriously jeopardize
7 the life or health of the covered person or the ability of the covered
8 person to regain maximum function, or [(B)] (ii) in the opinion of a
9 health care professional with knowledge of the covered person's
10 medical condition, would subject the covered person to severe pain
11 that cannot be adequately managed without the health care service or
12 treatment being requested, (B) for a substance use disorder, as
13 described in section 17a-458, or for a co-occurring mental disorder, or

14 (C) for a mental disorder, for inpatient services, partial hospitalization,
15 as defined in section 38a-496, or intensive outpatient services necessary
16 to keep a covered person from requiring an inpatient setting.

17 Sec. 2. Subsections (a) to (c), inclusive, of section 38a-591d of the
18 general statutes are repealed and the following is substituted in lieu
19 thereof (*Effective October 1, 2013*):

20 (a) (1) Each health carrier shall maintain written procedures for (A)
21 utilization review and benefit determinations, (B) expedited utilization
22 review and benefit determinations with respect to prospective urgent
23 care requests and concurrent review urgent care requests, and (C)
24 notifying covered persons or covered persons' authorized
25 representatives of such review and benefit determinations. Each health
26 carrier shall make such review and benefit determinations within the
27 specified time periods under this section.

28 (2) In determining whether a benefit request shall be considered an
29 urgent care request, an individual acting on behalf of a health carrier
30 shall apply the judgment of a prudent layperson who possesses an
31 average knowledge of health and medicine, except that any benefit
32 request (A) determined to be an urgent care request by a health care
33 professional with knowledge of the covered person's medical
34 condition, or (B) specified under subparagraph (B) or (C) of
35 subdivision (38) of section 38a-591a, as amended by this act, shall be
36 deemed an urgent care request.

37 (b) With respect to a nonurgent care request:

38 (1) (A) For a prospective or concurrent review request, a health
39 carrier shall make a determination within a reasonable period of time
40 appropriate to the covered person's medical condition, but not later
41 than fifteen calendar days after the date the health carrier receives such
42 request, and shall notify the covered person and, if applicable, the
43 covered person's authorized representative of such determination,
44 whether or not the carrier certifies the provision of the benefit.

45 (B) If the review under subparagraph (A) of this subdivision is a
46 concurrent review request, pursuant to 45 CFR 147.136, as amended
47 from time to time, the treatment shall be continued without liability to
48 the covered person for the duration of such review or any grievance
49 filed by a covered person or a covered person's authorized
50 representative pursuant to section 38a-591e, as amended by this act, or
51 38a-591f, as amended by this act, of an adverse determination or a final
52 adverse determination of such concurrent review.

53 (2) For a retrospective review request, a health carrier shall make a
54 determination within a reasonable period of time, but not later than
55 thirty calendar days after the date the health carrier receives such
56 request.

57 (3) The time periods specified in subdivisions (1) and (2) of this
58 subsection may be extended once by the health carrier for up to fifteen
59 calendar days, provided the health carrier:

60 (A) Determines that an extension is necessary due to circumstances
61 beyond the health carrier's control; and

62 (B) Notifies the covered person and, if applicable, the covered
63 person's authorized representative prior to the expiration of the initial
64 time period, of the circumstances requiring the extension of time and
65 the date by which the health carrier expects to make a determination.

66 (4) (A) If the extension pursuant to subdivision (3) of this subsection
67 is necessary due to the failure of the covered person or the covered
68 person's authorized representative to provide information necessary to
69 make a determination on the request, the health carrier shall:

70 (i) Specifically describe in the notice of extension the required
71 information necessary to complete the request; and

72 (ii) Provide the covered person and, if applicable, the covered
73 person's authorized representative with not less than forty-five

74 calendar days after the date of receipt of the notice to provide the
75 specified information.

76 (B) If the covered person or the covered person's authorized
77 representative fails to submit the specified information before the end
78 of the period of the extension, the health carrier may deny certification
79 of the benefit requested.

80 (c) With respect to an urgent care request:

81 (1) Unless the covered person or the covered person's authorized
82 representative has failed to provide information necessary for the
83 health carrier to make a determination, the health carrier shall make a
84 determination as soon as possible, taking into account the covered
85 person's medical condition, but not later than [seventy-two] twenty-
86 four hours after the health carrier receives such request, provided, if
87 the urgent care request is a concurrent review request to extend a
88 course of treatment beyond the initial period of time or the number of
89 treatments, such request is made at least twenty-four hours prior to the
90 expiration of the prescribed period of time or number of treatments;

91 (2) (A) If the covered person or the covered person's authorized
92 representative has failed to provide information necessary for the
93 health carrier to make a determination, the health carrier shall notify
94 the covered person or the covered person's representative, as
95 applicable, as soon as possible, but not later than twenty-four hours
96 after the health carrier receives such request.

97 (B) The health carrier shall provide the covered person or the
98 covered person's authorized representative, as applicable, a reasonable
99 period of time to submit the specified information, taking into account
100 the covered person's medical condition, but not less than forty-eight
101 hours after notifying the covered person or the covered person's
102 authorized representative, as applicable.

103 (3) The health carrier shall notify the covered person and, if

104 applicable, the covered person's authorized representative of its
105 determination as soon as possible, but not later than forty-eight hours
106 after the earlier of (A) the date on which the covered person and the
107 covered person's authorized representative, as applicable, provides the
108 specified information to the health carrier, or (B) the date on which the
109 specified information was to have been submitted.

110 Sec. 3. Subsection (e) of section 38a-591d of the general statutes is
111 repealed and the following is substituted in lieu thereof (*Effective*
112 *October 1, 2013*):

113 (e) Each health carrier shall provide promptly to a covered person
114 and, if applicable, the covered person's authorized representative a
115 notice of an adverse determination.

116 (1) Such notice [may] shall be provided in writing or by electronic
117 means and shall set forth, in a manner calculated to be understood by
118 the covered person or the covered person's authorized representative:

119 (A) Information sufficient to identify the benefit request or claim
120 involved, including the date of service, if applicable, the health care
121 professional and the claim amount;

122 (B) The specific reason or reasons for the adverse determination, a
123 listing of any clinical review criteria, including professional criteria
124 and medical or scientific evidence and a description of the health
125 carrier's standard, if any, that [was] were used in reaching the denial;

126 (C) Reference to the specific health benefit plan provisions on which
127 the determination is based;

128 (D) A description of any additional material or information
129 necessary for the covered person to perfect the benefit request or claim,
130 including an explanation of why the material or information is
131 necessary to perfect the request or claim;

132 (E) A description of the health carrier's internal grievance process

133 that includes (i) the health carrier's expedited review procedures, (ii)
134 any time limits applicable to such process or procedures, (iii) the
135 contact information for the organizational unit designated to
136 coordinate the review on behalf of the health carrier, and (iv) a
137 statement that the covered person or, if applicable, the covered
138 person's authorized representative is entitled, pursuant to the
139 requirements of the health carrier's internal grievance process, to [(I)
140 submit written comments, documents, records and other material
141 relating to the covered person's benefit request for consideration by the
142 individual or individuals conducting the review, and (II)] receive from
143 the health carrier, free of charge upon request, reasonable access to and
144 copies of all documents, records, communications and other
145 information and evidence regarding the covered person's benefit
146 request;

147 (F) If the adverse determination is based on a health carrier's
148 internal rule, guideline, protocol or other similar criterion, (i) the
149 specific rule, guideline, protocol or other similar criterion, or (ii) a
150 statement that a specific rule, guideline, protocol or other similar
151 criterion of the health carrier was relied upon to make the adverse
152 determination and that a copy of such rule, guideline, protocol or other
153 similar criterion will be provided to the covered person free of charge
154 upon request, and instructions for requesting such copy;

155 (G) If the adverse determination is based on medical necessity or an
156 experimental or investigational treatment or similar exclusion or limit,
157 the written statement of the scientific or clinical rationale for the
158 adverse determination and (i) an explanation of the scientific or clinical
159 rationale used to make the determination that applies the terms of the
160 health benefit plan to the covered person's medical circumstances or
161 (ii) a statement that an explanation will be provided to the covered
162 person free of charge upon request, and instructions for requesting a
163 copy of such explanation; [and]

164 (H) A statement explaining the right of the covered person to

165 contact the commissioner's office or the Office of the Healthcare
166 Advocate at any time for assistance or, upon completion of the health
167 carrier's internal grievance process, to file a civil suit in a court of
168 competent jurisdiction. Such statement shall include the contact
169 information for said offices; and

170 (I) A statement that if the covered person or the covered person's
171 authorized representative chooses to file a grievance of an adverse
172 determination, (i) such appeals are sometimes successful, (ii) such
173 covered person or covered person's authorized representative may
174 benefit from free assistance from the Office of the Healthcare
175 Advocate, which can assist such covered person or covered person's
176 authorized representative with the filing of a grievance pursuant to 42
177 USC 300gg-93, as amended from time to time, (iii) such covered person
178 or covered person's authorized representative is entitled and
179 encouraged to submit supporting documentation for the health
180 carrier's consideration during the review of an adverse determination,
181 including narratives from such covered person or covered person's
182 authorized representative and letters and treatment notes from such
183 covered person's health care professional, and (iv) such covered person
184 or covered person's authorized representative has the right to ask such
185 covered person's health care professional for such letters or treatment
186 notes.

187 (2) Upon request pursuant to subparagraph (E) of subdivision (1) of
188 this subsection, the health carrier shall provide such copies in
189 accordance with subsection (a) of section 38a-591n.

190 Sec. 4. Subdivision (3) of subsection (c) of section 38a-591e of the
191 general statutes is repealed and the following is substituted in lieu
192 thereof (*Effective October 1, 2013*):

193 (3) If the review under subdivision (1) of this subsection is an
194 expedited review of a grievance involving an adverse determination of
195 a concurrent review urgent care request, pursuant to 45 CFR 147.136,

196 as amended from time to time, the treatment shall be continued
197 without liability to the covered person until the covered person has
198 been notified of the review decision.

199 Sec. 5. Subsection (d) of section 38a-591e of the general statutes is
200 repealed and the following is substituted in lieu thereof (*Effective*
201 *October 1, 2013*):

202 (d) (1) The health carrier shall notify the covered person and, if
203 applicable, the covered person's authorized representative, in writing
204 or by electronic means, of its decision within a reasonable period of
205 time appropriate to the covered person's medical condition, but not
206 later than:

207 (A) For prospective review and concurrent review requests, thirty
208 calendar days after the health carrier receives the grievance;

209 (B) For retrospective review requests, sixty calendar days after the
210 health carrier receives the grievance; and

211 (C) For expedited review requests, [seventy-two] twenty-four hours
212 after the health carrier receives the grievance.

213 (2) The time periods set forth in subdivision (1) of this subsection
214 shall apply regardless of whether all of the information necessary to
215 make a decision accompanies the filing.

216 Sec. 6. Subsection (d) of section 38a-591f of the general statutes is
217 repealed and the following is substituted in lieu thereof (*Effective*
218 *October 1, 2013*):

219 (d) (1) The written decision issued pursuant to subsection (c) of this
220 section shall contain:

221 (A) The titles and qualifying credentials of the individual or
222 individuals participating in the review process;

223 (B) A statement of such individual's or individuals' understanding
224 of the covered person's grievance;

225 (C) The individual's or individuals' decision in clear terms and the
226 health benefit plan contract basis for such decision in sufficient detail
227 for the covered person to respond further to the health carrier's
228 position;

229 (D) Reference to the documents, communications, information and
230 evidence used as the basis for the decision; and

231 (E) For a decision that upholds the adverse determination, a
232 statement (i) that the covered person may receive from the health
233 carrier, free of charge and upon request, reasonable access to and
234 copies of, all documents, communications, information and evidence
235 regarding the adverse determination that is the subject of the final
236 adverse determination, and (ii) disclosing the covered person's right to
237 contact the commissioner's office or the Office of the Healthcare
238 Advocate at any time, and that such covered person may benefit from
239 free assistance from the Office of the Healthcare Advocate, which can
240 assist such covered person with the filing of a grievance pursuant to 42
241 USC 300gg-93, as amended from time to time. Such disclosure shall
242 include the contact information for said offices.

243 (2) Upon request pursuant to subparagraph (E) of subdivision (1) of
244 this subsection, the health carrier shall provide such copies in
245 accordance with subsection (b) of section 38a-591n.

246 Sec. 7. Subdivision (1) of subsection (i) of section 38a-591g of the
247 general statutes is repealed and the following is substituted in lieu
248 thereof (*Effective October 1, 2013*):

249 (i) (1) The independent review organization shall notify the
250 commissioner, the health carrier, the covered person and, if applicable,
251 the covered person's authorized representative in writing of its
252 decision to uphold, reverse or revise the adverse determination or the

253 final adverse determination, not later than:

254 (A) For external reviews, forty-five calendar days after such
255 organization receives the assignment from the commissioner to
256 conduct such review;

257 (B) For external reviews involving a determination that the
258 recommended or requested health care service or treatment is
259 experimental or investigational, twenty calendar days after such
260 organization receives the assignment from the commissioner to
261 conduct such review;

262 (C) For expedited external reviews, as expeditiously as the covered
263 person's medical condition requires, but not later than [seventy-two]
264 twenty-four hours after such organization receives the assignment
265 from the commissioner to conduct such review; and

266 (D) For expedited external reviews involving a determination that
267 the recommended or requested health care service or treatment is
268 experimental or investigational, as expeditiously as the covered
269 person's medical condition requires, but not later than five calendar
270 days after such organization receives the assignment from the
271 commissioner to conduct such review.

272 Sec. 8. Subdivision (7) of section 38a-591a of the general statutes is
273 repealed and the following is substituted in lieu thereof (*Effective July*
274 *1, 2014*):

275 (7) "Clinical peer" means a [physician or other] health care
276 professional who [holds a nonrestricted license in a state of the United
277 States and in the same or similar specialty as typically manages the
278 medical condition, procedure or treatment under review] is licensed in
279 this state or in another state that requires the same or greater
280 qualifications for licensure, and:

281 (A) (i) Is certified by an appropriate national board as a medical

282 specialist, is trained and has clinical experience in a medical specialty
283 or who holds himself or herself out as a medical specialist; or

284 (ii) If such health care professional is not certified by an appropriate
285 national board as a medical specialist, is not trained and does not have
286 clinical experience in a medical specialty or does not hold himself or
287 herself out as a medical specialist, is trained and experienced in a
288 medical discipline or school of practice and has at least five years'
289 active practice or teaching in such discipline or school of practice
290 immediately preceding such health care professional's initial date of
291 service with a health carrier or an independent review organization; or

292 (B) For a review or benefit determination concerning a child or
293 adolescent substance use disorder treatment, as such disorder is
294 described in section 17a-458, or a child or adolescent mental disorder,
295 holds a national board certification in child and adolescent psychiatry
296 or child and adolescent psychology, and has training or clinical
297 experience in the treatment of child and adolescent substance use or
298 child and adolescent mental disorder, as applicable.

299 Sec. 9. Section 38a-591c of the general statutes is repealed and the
300 following is substituted in lieu thereof (*Effective July 1, 2014*):

301 (a) (1) Each health carrier shall contract with (A) health care
302 professionals to administer such health carrier's utilization review
303 program, [and oversee utilization review determinations,] and (B)
304 [with] clinical peers to conduct utilization reviews and benefit
305 determinations and to evaluate the clinical appropriateness of an
306 adverse determination.

307 (2) (A) Each utilization review program shall use documented
308 clinical review criteria that are based on sound clinical evidence and
309 are evaluated periodically by the health carrier's organizational
310 mechanism specified in subparagraph (F) of subdivision (2) of
311 subsection (c) of section 38a-591b to assure such program's ongoing
312 effectiveness. A health carrier may develop its own clinical review

313 criteria or it may purchase or license clinical review criteria from
314 qualified vendors approved by the commissioner. Each health carrier
315 shall make its clinical review criteria available upon request to
316 authorized government agencies.

317 (B) Notwithstanding subparagraph (A) of this subdivision, for any
318 utilization review or benefit determination for the treatment of a
319 substance use disorder, as described in section 17a-458, the clinical
320 review criteria used shall be: (i) The most recent edition of the
321 American Society of Addiction Medicine's Patient Placement Criteria;
322 or (ii) clinical review criteria that are (I) developed as required under
323 state law, and (II) reviewed and accepted by the Department of Mental
324 Health and Addiction Services for adults and the Department of
325 Children and Families for children and adolescents, as adhering to the
326 prevailing standard of care.

327 (C) A health carrier that uses clinical review criteria as set forth in
328 subparagraph (B)(ii) of this subdivision shall create and maintain a
329 document that (i) compares each aspect of such clinical review criteria
330 with the American Society of Addiction Medicine's Patient Placement
331 Criteria, and (ii) provides citations to peer-reviewed medical literature
332 generally recognized by the relevant medical community or to
333 professional society guidelines that justify each deviation from the
334 American Society of Addiction Medicine's Patient Placement Criteria.

335 (D) Notwithstanding subparagraph (A) of this subdivision, for any
336 utilization review or benefit determination for the treatment of a
337 mental disorder, the clinical review criteria used shall be: (i) For
338 children and adolescents, the most recent guidelines in the American
339 Academy of Child and Adolescent Psychiatry's Child and Adolescent
340 Service Intensity Instrument; or (ii) clinical review criteria that are (I)
341 developed as required under state law, and (II) reviewed and accepted
342 by the Department of Mental Health and Addiction Services for adults
343 and the Department of Children and Families for children and
344 adolescents, as adhering to the prevailing standard of care.

345 (E) A health carrier that uses clinical review criteria as set forth in
346 subparagraph (D)(ii) of this subdivision for children and adolescents
347 shall create and maintain a document that (i) compares each aspect of
348 such clinical review criteria with the guidelines in the American
349 Academy of Child and Adolescent Psychiatry's Child and Adolescent
350 Service Intensity Instrument, and (ii) provides citations to peer-
351 reviewed medical literature generally recognized by the relevant
352 medical community or to professional society guidelines that justify
353 each deviation from the guidelines in the American Academy of Child
354 and Adolescent Psychiatry's Child and Adolescent Service Intensity
355 Instrument.

356 (b) Each health carrier shall:

357 (1) Have procedures in place to ensure that (A) the health care
358 professionals administering such health carrier's utilization review
359 program are applying the clinical review criteria consistently in
360 utilization review determinations, and (B) the appropriate or required
361 clinical peers are being designated to conduct utilization reviews and
362 benefit determinations;

363 (2) Have data systems sufficient to support utilization review
364 program activities and to generate management reports to enable the
365 health carrier to monitor and manage health care services effectively;

366 (3) Provide covered persons and participating providers with access
367 to its utilization review staff through a toll-free telephone number or
368 any other free calling option or by electronic means;

369 (4) Coordinate the utilization review program with other medical
370 management activity conducted by the health carrier, such as quality
371 assurance, credentialing, contracting with health care professionals,
372 data reporting, grievance procedures, processes for assessing member
373 satisfaction and risk management; and

374 (5) Routinely assess the effectiveness and efficiency of its utilization

375 review program.

376 (c) If a health carrier delegates any utilization review activities to a
377 utilization review company, the health carrier shall maintain adequate
378 oversight, which shall include (1) a written description of the
379 utilization review company's activities and responsibilities, including
380 such company's reporting requirements, (2) evidence of the health
381 carrier's formal approval of the utilization review company program,
382 and (3) a process by which the health carrier shall evaluate the
383 utilization review company's performance.

384 (d) When conducting utilization review, the health carrier shall (1)
385 collect only the information necessary, including pertinent clinical
386 information, to make the utilization review or benefit determination,
387 and (2) ensure that such review is conducted in a manner to ensure the
388 independence and impartiality of the [individual or individuals]
389 clinical peer or peers involved in making the utilization review or
390 benefit determination. No health carrier shall make decisions
391 regarding the hiring, compensation, termination, promotion or other
392 similar matters of such [individual or individuals] clinical peer or
393 peers based on the likelihood that the [individual or individuals]
394 clinical peer or peers will support the denial of benefits.

395 Sec. 10. Section 38a-591e of the general statutes, as amended by
396 sections 4 and 5 of this act, is repealed and the following is substituted
397 in lieu thereof (*Effective July 1, 2014*):

398 (a) (1) Each health carrier shall establish and maintain written
399 procedures for (A) the review of grievances of adverse determinations
400 that were based, in whole or in part, on medical necessity, (B) the
401 expedited review of grievances of adverse determinations of urgent
402 care requests, including concurrent review urgent care requests
403 involving an admission, availability of care, continued stay or health
404 care service for a covered person who has received emergency services
405 but has not been discharged from a facility, and (C) notifying covered

406 persons or covered persons' authorized representatives of such
407 adverse determinations.

408 (2) Each health carrier shall file with the commissioner a copy of
409 such procedures, including all forms used to process requests, and any
410 subsequent material modifications to such procedures.

411 (3) In addition to a copy of such procedures, each health carrier shall
412 file annually with the commissioner, as part of its annual report
413 required under subsection (e) of section 38a-591b, a certificate of
414 compliance stating that the health carrier has established and
415 maintains grievance procedures for each of its health benefit plans that
416 are fully compliant with the provisions of sections 38a-591a to 38a-
417 591n, inclusive, as amended by this act.

418 (b) (1) A covered person or a covered person's authorized
419 representative may file a grievance of an adverse determination that
420 was based, in whole or in part, on medical necessity with the health
421 carrier not later than one hundred eighty calendar days after the
422 covered person or the covered person's authorized representative, as
423 applicable, receives the notice of an adverse determination.

424 (2) For prospective or concurrent urgent care requests, a covered
425 person or a covered person's authorized representative may make a
426 request for an expedited review orally or in writing.

427 (c) (1) (A) When conducting a review of an adverse determination
428 under this section, the health carrier shall ensure that such review is
429 conducted in a manner to ensure the independence and impartiality of
430 the [individual or individuals] clinical peer or peers involved in
431 making the review decision.

432 (B) If the adverse determination involves utilization review, the
433 health carrier shall designate an appropriate clinical peer or peers to
434 review such adverse determination. Such clinical peer or peers shall
435 not have been involved in the initial adverse determination.

436 (C) The [individual or individuals] clinical peer or peers conducting
437 a review under this section shall take into consideration all comments,
438 documents, records and other information relevant to the covered
439 person's benefit request that is the subject of the adverse determination
440 under review, that are submitted by the covered person or the covered
441 person's authorized representative, regardless of whether such
442 information was submitted or considered in making the initial adverse
443 determination.

444 (D) Prior to issuing a decision, the health carrier shall provide free
445 of charge, by facsimile, electronic means or any other expeditious
446 method available, to the covered person or the covered person's
447 authorized representative, as applicable, any new or additional
448 documents, communications, information and evidence relied upon
449 and any new or additional scientific or clinical rationale used by the
450 health carrier in connection with the grievance. Such documents,
451 communications, information, evidence and rationale shall be
452 provided sufficiently in advance of the date the health carrier is
453 required to issue a decision to permit the covered person or the
454 covered person's authorized representative, as applicable, a reasonable
455 opportunity to respond prior to such date.

456 (2) If the review under subdivision (1) of this subsection is an
457 expedited review, all necessary information, including the health
458 carrier's decision, shall be transmitted between the health carrier and
459 the covered person or the covered person's authorized representative,
460 as applicable, by telephone, facsimile, electronic means or any other
461 expeditious method available.

462 (3) If the review under subdivision (1) of this subsection is an
463 expedited review of a grievance involving an adverse determination of
464 a concurrent review urgent care request, pursuant to 45 CFR 147.136,
465 as amended from time to time, the treatment shall be continued
466 without liability to the covered person until the covered person has
467 been notified of the review decision.

468 (d) (1) The health carrier shall notify the covered person and, if
469 applicable, the covered person's authorized representative, in writing
470 or by electronic means, of its decision within a reasonable period of
471 time appropriate to the covered person's medical condition, but not
472 later than:

473 (A) For prospective review and concurrent review requests, thirty
474 calendar days after the health carrier receives the grievance;

475 (B) For retrospective review requests, sixty calendar days after the
476 health carrier receives the grievance; and

477 (C) For expedited review requests, twenty-four hours after the
478 health carrier receives the grievance.

479 (2) The time periods set forth in subdivision (1) of this subsection
480 shall apply regardless of whether all of the information necessary to
481 make a decision accompanies the filing.

482 (e) (1) The notice required under subsection (d) of this section shall
483 set forth, in a manner calculated to be understood by the covered
484 person or the covered person's authorized representative:

485 (A) The titles and qualifying credentials of the [individual or
486 individuals] clinical peer or peers participating in the review process;

487 (B) Information sufficient to identify the claim involved with respect
488 to the grievance, including the date of service, if applicable, the health
489 care professional and the claim amount;

490 (C) A statement of such [individual's or individuals'] clinical peer's
491 or peers' understanding of the covered person's grievance;

492 (D) The [individual's or individuals'] clinical peer's or peers'
493 decision in clear terms and the health benefit plan contract basis or
494 scientific or clinical rationale for such decision in sufficient detail for
495 the covered person to respond further to the health carrier's position;

496 (E) Reference to the evidence or documentation used as the basis for
497 the decision;

498 (F) For a decision that upholds the adverse determination:

499 (i) The specific reason or reasons for the final adverse
500 determination, including the denial code and its corresponding
501 meaning, as well as a description of the health carrier's standard, if
502 any, that was used in reaching the denial;

503 (ii) Reference to the specific health benefit plan provisions on which
504 the decision is based;

505 (iii) A statement that the covered person may receive from the
506 health carrier, free of charge and upon request, reasonable access to
507 and copies of, all documents, records, communications and other
508 information and evidence not previously provided regarding the
509 adverse determination under review;

510 (iv) If the final adverse determination is based on a health carrier's
511 internal rule, guideline, protocol or other similar criterion, (I) the
512 specific rule, guideline, protocol or other similar criterion, or (II) a
513 statement that a specific rule, guideline, protocol or other similar
514 criterion of the health carrier was relied upon to make the final adverse
515 determination and that a copy of such rule, guideline, protocol or other
516 similar criterion will be provided to the covered person free of charge
517 upon request and instructions for requesting such copy;

518 (v) If the final adverse determination is based on medical necessity
519 or an experimental or investigational treatment or similar exclusion or
520 limit, the written statement of the scientific or clinical rationale for the
521 final adverse determination and (I) an explanation of the scientific or
522 clinical rationale used to make the determination that applies the terms
523 of the health benefit plan to the covered person's medical
524 circumstances, or (II) a statement that an explanation will be provided
525 to the covered person free of charge upon request and instructions for

526 requesting a copy of such explanation;

527 (vi) A statement describing the procedures for obtaining an external
528 review of the final adverse determination;

529 (G) If applicable, the following statement: "You and your plan may
530 have other voluntary alternative dispute resolution options such as
531 mediation. One way to find out what may be available is to contact
532 your state Insurance Commissioner."; and

533 (H) A statement disclosing the covered person's right to contact the
534 commissioner's office or the Office of the Healthcare Advocate at any
535 time. Such disclosure shall include the contact information for said
536 offices.

537 (2) Upon request pursuant to subparagraph (F)(iii) of subdivision (1)
538 of this subsection, the health carrier shall provide such copies in
539 accordance with subsection (b) of section 38a-591n.

540 (f) (1) Whenever a health carrier fails to strictly adhere to the
541 requirements of this section with respect to receiving and resolving
542 grievances involving an adverse determination, the covered person
543 shall be deemed to have exhausted the internal grievance process of
544 such health carrier and may file a request for an external review,
545 regardless of whether the health carrier asserts that it substantially
546 complied with the requirements of this section, or that any error it
547 committed was de minimis.

548 (2) A covered person who has exhausted the internal grievance
549 process of a health carrier may, in addition to filing a request for an
550 external review, pursue any available remedies under state or federal
551 law on the basis that the health carrier failed to provide a reasonable
552 internal grievance process that would yield a decision on the merits of
553 the claim.

554 Sec. 11. Subsection (a) of section 38a-591d of the general statutes, as

555 amended by section 2 of this act, is repealed and the following is
556 substituted in lieu thereof (*Effective July 1, 2014*):

557 (a) (1) Each health carrier shall maintain written procedures for (A)
558 utilization review and benefit determinations, (B) expedited utilization
559 review and benefit determinations with respect to prospective urgent
560 care requests and concurrent review urgent care requests, and (C)
561 notifying covered persons or covered persons' authorized
562 representatives of such review and benefit determinations. Each health
563 carrier shall make such review and benefit determinations within the
564 specified time periods under this section.

565 (2) [In determining whether a benefit request shall be considered an
566 urgent care request, an individual acting on behalf of a health carrier
567 shall apply the judgment of a prudent layperson who possesses an
568 average knowledge of health and medicine, except that any] Any
569 benefit request (A) determined to be an urgent care request by a health
570 care professional with knowledge of the covered person's medical
571 condition, or (B) specified under subparagraph (B) or (C) of
572 subdivision (38) of section 38a-591a, as amended by this act, shall be
573 deemed an urgent care request.

574 Sec. 12. Subsection (c) of section 38a-591l of the general statutes is
575 repealed and the following is substituted in lieu thereof (*Effective July*
576 *1, 2014*):

577 (c) To be eligible for approval by the commissioner, an independent
578 review organization shall:

579 (1) Have and maintain written policies and procedures that govern
580 all aspects of both the standard external review process and the
581 expedited external review process set forth in section 38a-591g, as
582 amended by this act, that include, at a minimum:

583 (A) A quality assurance mechanism in place that ensures:

584 (i) That external reviews and expedited external reviews are
585 conducted within the specified time frames and required notices are
586 provided in a timely manner;

587 (ii) (I) The selection of qualified and impartial clinical peers to
588 conduct such reviews on behalf of the independent review
589 organization and the suitable matching of such peers to specific cases,
590 and (II) the employment of or the contracting with an adequate
591 number of clinical peers to meet this objective;

592 (iii) The confidentiality of medical and treatment records and
593 clinical review criteria;

594 (iv) That any person employed by or under contract with the
595 independent review organization adheres to the requirements of
596 section 38a-591g, as amended by this act; and

597 (B) A toll-free telephone number to receive information twenty-four
598 hours a day, seven days a week, related to external reviews and
599 expedited external reviews and that is capable of accepting, recording
600 or providing appropriate instruction to incoming telephone callers
601 during other than normal business hours;

602 (2) Agree to maintain and provide to the commissioner the
603 information set forth in section 38a-591m;

604 (3) Not own or control, be a subsidiary of, be owned or controlled in
605 any way by, or exercise control with a health benefit plan, a national,
606 state or local trade association of health benefit plans, or a national,
607 state or local trade association of health care professionals; and

608 [(4) Assign as a clinical peer a health care professional who meets
609 the following minimum qualifications:

610 (A) Is an expert in the treatment of the covered person's medical
611 condition that is the subject of the review;

612 (B) Is knowledgeable about the recommended health care service or
613 treatment through recent or current actual clinical experience treating
614 patients with the same or similar medical condition of the covered
615 person;

616 (C) Holds a nonrestricted license in a state of the United States and,
617 for physicians, a current certification by a recognized American
618 medical specialty board in the area or areas appropriate to the subject
619 of the review; and]

620 [(D) Has] (4) Assign as a clinical peer a health care professional who
621 has no history of disciplinary actions or sanctions, including loss of
622 staff privileges or participation restrictions, that have been taken or are
623 pending by any hospital, governmental agency or unit or regulatory
624 body that raise a substantial question as to the clinical peer's physical,
625 mental or professional competence or moral character.

626 Sec. 13. Section 38a-478~~l~~ of the general statutes is amended by
627 adding subsection (e) as follows (*Effective October 1, 2013*):

628 (NEW) (e) The commissioner shall analyze annually the data
629 submitted under subparagraphs (E) and (F) of subdivision (1) of
630 subsection (b) of this section for the accuracy of, trends in and
631 statistically significant differences in such data among the health care
632 centers and licensed health insurers included in the consumer report
633 card. The commissioner shall investigate any such differences to
634 determine whether further action by the commissioner is warranted.

635 Sec. 14. Section 38a-1040 of the general statutes is repealed and the
636 following is substituted in lieu thereof (*Effective October 1, 2013*):

637 As used in sections 38a-1040 to 38a-1050, inclusive:

638 (1) "Consumer" means an individual who receives or is attempting
639 to receive services from a managed care organization and is a resident
640 of this state, or such individual's authorized representative, as defined

641 in section 38a-591a, as amended by this act.

642 (2) "Managed care organization" means an insurer, health care
643 center, hospital [or] service corporation, medical service corporation or
644 other organization delivering, issuing for delivery, renewing, [or]
645 amending or continuing any individual or group health managed care
646 plan in this state.

647 (3) "Managed care plan" means a [product offered by a managed
648 care organization that provides for the financing or delivery of health
649 care services to persons enrolled in the plan through: (A)
650 Arrangements with selected providers to furnish health care services;
651 (B) explicit standards for the selection of participating providers; (C)
652 financial incentives for enrollees to use the participating providers and
653 procedures provided for by the plan; or (D) arrangements that share
654 risks with providers, provided the organization offering a plan
655 described under subparagraph (A), (B), (C) or (D) of this subdivision is
656 licensed by the Insurance Department pursuant to chapter 698, 698a or
657 700 and that the plan includes utilization review, as defined in section
658 38a-591a] health insurance policy or health care plan that provides
659 coverage of the types specified in section 38a-469 or that are governed
660 by federal law.

661 Sec. 15. Section 38a-1046 of the general statutes is repealed and the
662 following is substituted in lieu thereof (*Effective October 1, 2013*):

663 Each employer [, other than a self-insured employer,] that provides
664 health insurance or health care benefits to employees shall obtain from
665 the Healthcare Advocate and post, in a conspicuous location, a notice
666 concerning the services that the Healthcare Advocate provides.

667 Sec. 16. (*Effective from passage*) (a) Not later than September 1, 2013,
668 the Insurance Commissioner shall submit a report, in accordance with
669 the provisions of section 11-4a of the general statutes, to the joint
670 standing committees of the General Assembly having cognizance of
671 matters relating to insurance and public health on the method the

672 Insurance Department shall use to check for compliance with state and
673 federal mental health parity laws by health insurance companies and
674 other entities under its jurisdiction. In selecting such method, the
675 commissioner shall examine and assess for fitness the methods set
676 forth by the United States Department of Labor and URAC, in addition
677 to any other methods discovered by or brought to the attention of the
678 Insurance Department. As part of the evaluation process, the
679 commissioner shall hold at least one public meeting at which
680 stakeholders, including, but not limited to, relevant state agency
681 personnel, health insurance companies and the general public, are
682 invited to share their input and propose other compliance check
683 methods.

684 (b) The report under subsection (a) of this section shall describe and
685 address the comments shared at the public meeting or meetings,
686 include an assessment of each potential method examined and append
687 written comments and suggestions of the Healthcare Advocate.

688 (c) On or before October 1, 2013, the commissioner shall begin such
689 compliance checks using the compliance check method selected.

690 Sec. 17. Section 38a-478a of the general statutes is repealed and the
691 following is substituted in lieu thereof (*Effective October 1, 2013*):

692 On March first annually, the Insurance Commissioner shall submit a
693 report to the Governor and to the joint standing committees of the
694 General Assembly having cognizance of matters relating to public
695 health and insurance, concerning the commissioner's responsibilities
696 under the provisions of sections 38a-478 to 38a-478u, inclusive, 38a-
697 479aa, 38a-591a to 38a-591h, inclusive, and 38a-993. The report shall
698 include: (1) A summary of the quality assurance plans submitted by
699 managed care organizations pursuant to section 38a-478c along with
700 suggested changes to improve such plans; (2) suggested modifications
701 to the consumer report card developed under the provisions of section
702 38a-478l; (3) a summary of the commissioner's procedures and

703 activities in conducting market conduct examinations of utilization
704 review companies and preferred provider networks, including, but not
705 limited to: (A) The number of desk and field audits completed during
706 the previous calendar year; (B) a summary of findings of the desk and
707 field audits, including any recommendations made for improvements
708 or modifications; (C) a description of complaints concerning managed
709 care companies, and any preferred provider network that provides
710 services to enrollees on behalf of the managed care organization,
711 including a summary and analysis of any trends or similarities found
712 in the managed care complaints filed by enrollees; (4) a summary of
713 the complaints concerning managed care organizations received by the
714 Insurance Department's Consumer Affairs Division and the
715 commissioner under section 38a-591g, as amended by this act,
716 including a summary and analysis of any trends or similarities found
717 in the complaints received; (5) a summary of any violations the
718 commissioner has found against any managed care organization or
719 any preferred provider network that provides services to enrollees on
720 behalf of the managed care organization; [and] (6) a summary of the
721 issues discussed related to health care or managed care organizations
722 at the Insurance Department's quarterly forums throughout the state;
723 and (7) a summary of the method used by the department to check for
724 compliance with state and federal mental health parity laws by health
725 insurance companies and other entities under its jurisdiction, and
726 results of such compliance checks.

This act shall take effect as follows and shall amend the following sections:		
Section 1	October 1, 2013	38a-591a(38)
Sec. 2	October 1, 2013	38a-591d(a) to (c)
Sec. 3	October 1, 2013	38a-591d(e)
Sec. 4	October 1, 2013	38a-591e(c)(3)
Sec. 5	October 1, 2013	38a-591e(d)
Sec. 6	October 1, 2013	38a-591f(d)
Sec. 7	October 1, 2013	38a-591g(i)(1)
Sec. 8	July 1, 2014	38a-591a(7)

Sec. 9	<i>July 1, 2014</i>	38a-591c
Sec. 10	<i>July 1, 2014</i>	38a-591e
Sec. 11	<i>July 1, 2014</i>	38a-591d(a)
Sec. 12	<i>July 1, 2014</i>	38a-591l(c)
Sec. 13	<i>October 1, 2013</i>	38a-478l
Sec. 14	<i>October 1, 2013</i>	38a-1040
Sec. 15	<i>October 1, 2013</i>	38a-1046
Sec. 16	<i>from passage</i>	New section
Sec. 17	<i>October 1, 2013</i>	38a-478a

Statement of Purpose:

To make changes to the health carrier review process for grievances of adverse determinations and final adverse determinations, to amend the Office of the Healthcare Advocate statutes to reflect said office's additional duties, and to require the Insurance Commissioner to select and use a method to check health insurance companies' and other entities' compliance with state and federal mental health parity laws and report on the results of such checks.

[Proposed deletions are enclosed in brackets. Proposed additions are indicated by underline, except that when the entire text of a bill or resolution or a section of a bill or resolution is new, it is not underlined.]